Montana ACA Home Visiting Program Narrative

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Inventory of Information/Data Available for Needs Assessment

Home visiting of maternal child health populations has a long history in Montana. Frontier nurses provided home visits to women in mining and agricultural communities in the late 1800s and early 1900s. Early accounts describe services that included prenatal care and infant care as well as counseling and support, recognizing that many families left behind their support systems when they traveled to the frontier.

Standardized home visiting services for pregnant women and young children began in the late 1980s with pilot programs in four communities. Funding from the state health agency was used to hire part time public health nurses to identify women, who needed help finding and paying for prenatal services, and to visit these women and assist them to access and attend prenatal care. These pilot projects were consistent with national trends to create programs that encouraged early entry into prenatal care with an end goal of improved pregnancy outcomes. Public health nurses in the four communities visited women in the women's homes, and the service, initially intended to be a single home visit to assess needs, instead became a variety of services provided through a series of visits. Originally intended as a program in which nurses referred women to physicians, the nurses quickly found themselves receiving referrals from primary care providers who requested assistance for their clients who needed transportation, housing, insurance, and other community services (Pettit, 2007). Based primarily on anecdotal reports from clients and providers regarding their satisfaction with the services, legislation was introduced to formalize and expand the program in 1989 (Espelin, 1990). Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) was envisioned to "ensure that mothers and children, particularity those with low income or limited availabilities for health services receive access to quality to maternal and child health care services" (*Hearing on House Bill 773*, 1989). The bill was presented as a mechanism to improve pregnancy outcomes and decrease infant mortality, and as a potential cost savings measure. Proponents claimed that the high cost of neonatal intensive care could potentially be resolved, in part, through the provision of comprehensive, coordinated services to high

risk pregnant women (Gallagher, Botsko, & Schwalberg, 2004). MIAMI was approved by the Montana legislature in 1989, with stated purposes of (1) ensuring that mothers and children receive access to quality maternal health services, (2) reducing infant mortality and the number of low birth weight babies (5½ pounds or less), and (3) preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care (Johnson, 2001). The state Department of Health implemented a series of strategies to address this legislation, including the expansion of the four pilot programs that offered home visiting services.

Montana's home visiting program originally targeted and continues to focus on "high risk" pregnant women and their infants. The original MIAMI program model identified risk factors as "moderating factors," identifying conditions that were perceived as potentially negatively affecting pregnancy outcomes, including demographics, pre-pregnancy health status, obstetric history, and socioeconomic factors (Espelin, 1990). Early program planning was based on work by Olds; however, unlike the Olds model, and due in great part to Montana's sparse population and limited public health resources, the program was open to all at risk women, regardless of maternal age or parity. A woman was considered "at risk" if she:

a. was age 17 years or younger;
b. had medical factors that indicate the potential for a poor pregnancy outcome;
c. used alcohol or illicit drugs or had someone in their immediate environment who used alcohol or drugs;
d. was in an abusive relationship; or
e. was homeless.

Medical risk factors were outlined in MIAMI Home Visiting manuals, and included history of preterm labor or delivery, history of chronic health conditions such as hypertension or diabetes, and/or pregnancy induced conditions including pre-ecclampsia or gestational diabetes. If a woman did not

qualify for services under these criteria, she could also be qualified if she demonstrated an "inability to obtain necessary resources and services" and met at least three of the following criteria:

a. had a history of physical or sexual abuse;
b. had no support system or involvement of a spouse or other supporting person;
c. had one or more children under age five;
d. was not educated beyond the 12th grade level;
e. had a physical disability or mental impairment;
f. had no prenatal care before or during the first 20 weeks of gestation;
g. was a refugee;
h. was age 18 or 19 years; or
i. had limited English proficiency (DPHHS, 2001).

Demographics of clients varied from contractor to contractor, with some programs serving only very young mothers, others serving high (or low) ratios of American Indians to white populations, and some serving almost exclusively Medicaid clients. In 2003, due in part to legislative scrutiny, an assessment of the data received from contractors revealed much variation in the delivery of home visiting services, the frequency of visits, and the per client costs. In order to standardize services and funding distribution, a request for proposals (RFP) for Public Health Home Visiting (PHHV) services was issued in 2003. The RFP established the home visiting team structure, the minimum standards for the number of women and infants to be served, the number of visits required during the prenatal and infant periods, and required the communities to describe the method of case finding and community outreach they would use. Sixteen proposals were received from communities, and fourteen contracts with county health departments were established in 2004. Since then, additional outreach and procurement activities resulted in the addition of two tribal program sites, however, due to staffing challenges, one of the tribal programs stopped providing services effective June 2010.

PHHV is one of many programs located in the Family and Community Health Bureau, which is

the designated Title V agency in the Department of Public Health and Human Services in Montana. Also located in the Bureau are the Maternal Child Health Epidemiology Unit and the Primary Care Office. The MCH Epidemiology Unit provides analytic support and staff to assist programs within the bureau to develop and implement evaluation strategies. Epidemiology Unit staff has worked closely with PHHV program staffs over the last several years to develop logic plans and mechanisms by which data may be gathered and utilized to both monitor and assess program activities. PHHV contracts require that client specific data is collected via standardized software, and that reports are exported and transmitted bi-annually to the state. Program staff manages the data and does quality checks using Excel, compiling the data into a single file to allow for statewide analysis. Depending upon the required analysis, the Excel files may also be converted to SPSS or SAS (depending on the individual analyst).

Several reports on the PHHV program were published in 2009, including a program report published in February 2009 (FCHB, 2009) and an evaluation of the PHHV program, which was completed as a research project for doctoral study by Jo Ann Walsh Dotson in Winter/Spring of 2009 (Dotson, 2009).

County level data required to assess the maternal child health population, including birth statistics and characteristics, is available in several locations and formats. Birth certificate data is available from the Vital Statistics Office, which is located in the Public Health and Safety Division (PHSD) with the Family and Community Health Bureau. Medicaid data is also available from the Health Resource Division within the Department. The PHSD is developing Community Health Assessment (CHA) documents, providing county level data for most of the indicators described in SSA Title V 511 (b) (1) (a). The CHA data being compiled by epidemiology staff within PHSD will be ready for distribution to county staff on July 28, 2010 at the Montana Summer Public Health Institute.

In preparation for the home visiting funding available via the Health Reform legislation, Montana added questions regarding home visiting to the annual MCH pre-contract survey which is sent to all fifty six counties. Counties are required to complete the pre-contract survey in order to receive

MCH block grant funding for the provision of MCH services. Fifty five of the 56 counties receive funding and therefore complete the survey, which has solicited information regarding county provision of home visiting services for approximately 8 years. This year, additional information was requested, including the model used (if any) for home visiting, and the contact information for home visiting services for the MCH population for non county health department home visit providers in the county. That survey, which was done in May of 2010, provided an extensive list of home visiting programs and services around the state. FCHB staff also met individually and in groups with state level government and non-government partners, including staffs from the department Director's office, the Early Childhood program, the Addictive and Mental Disorders Division, Medicaid, SCHIP, the Children's Trust Fund, and MCH advocacy organizations such as Healthy Mothers, Healthy Babies, the March of Dimes, the Montana Council for Maternal Child Health, in order to solicit information about existing MCH home visiting and to gather information and ideas regarding needs from those partners. On June 17th, FCHB staff conducted a statewide teleconference regarding MCH home visiting, which was attended by local and state partners. Since that teleconference, FCHB staff has followed up with other suggested contacts, including the Florence Crittenton Center for Pregnant and Parenting Teens. A follow up survey, conducted using an internet accessible survey tool, was sent to all identified programs, soliciting information about the type and numbers of populations served, models used, and perceived need for additional services. A federally supported graduate student (Maternal Child Health Bureau Graduate Student Intern Program) is compiling the information under the direction of the lead MCH epidemiologist, in preparation for the September first needs assessment submission. A second teleconference to review available data and solicit feedback from local and state partners is being scheduled for mid August.

Gaps in Available Data

As indicated above, Montana has in place systems to gather much of the data needed to effectively assess the need for and adequacy of home visiting services for the maternal child health

population. Two gaps are readily apparent. The first is data regarding the availability and adequacy of home visiting services for American Indian populations, on and off reservations. Montana has seven reservations that are home to eleven tribal nations, and one state recognized tribal nation that is landless. Approximately half of the American Indians in Montana live off reservation, receiving health and human services from government and non-government programs and agencies in their communities. Only one tribal community has a PHHV program, although most have Head Start programs. Indian Health Service and tribal data regarding risk status and birth outcomes is often difficult to obtain, and/or "tease out" of county and state data.

The second area of concern regarding home visiting data is regarding the "…extent to which such programs or initiatives are meeting the needs of eligible families". As noted above, Montana contracts with fourteen out of 56 counties and only one of seven tribal communities for PHHV services. Early Head Start, child care and other programs also provide some home visiting services for MCH populations, but often in the same communities where PHHV programs are offered. Approximately 75% (723,049 of 967,440) of the population lives in the counties where PHHV are offered; those same counties account for 76% (9,611 of 12,592) births (DPHHS, 2009). Therefore, about 25% of pregnant women and families with young children live in communities without PHHV services. Beyond the basic availability, the extent to which programs meet the needs of eligible families is a challenging and unique question to address. Research on home visiting frequently assesses the caregiver's perceptions of adequacy of service delivery; however there is limited research that documents families' perceptions regarding the degree to which home visiting met their needs. Assessment of adequacy also requires a clear understanding of the outcomes the program hoped to achieve. Many home visiting programs have broad goals such as "school readiness" or "improved maternal health". These broad goals may not be accompanied by measureable objectives OR the objectives may be questionably linked to the goals i.e. infant immunization rates for a program purportedly targeting maternal health. So while availability of

services may be assessed, the adequacy of the services received is anticipated to be challenging, unless adequacy or effectiveness is clearly defined.

State Capacity to Compile Data and Anticipated Obstacles

As stated earlier, the Family and Community Health Bureau is the designated Title V agency within the Montana Department of Public Health and Human Services. The Bureau has four sections and an MCH Epidemiology Unit. The Epidemiology Unit works with all sections on data management, analysis and interpretation. The PHHV program is part of the Maternal Child Health Coordination (MCHC) section. The MCHC section also houses the MCH Service contracts for 55 counties, the oral health program, the Fetal, Infant Child Mortality Review program, the Primary Care Office and fiscal and administrative support staff for the Bureau. Section staff includes Ms. Ann Buss MPA, who is the section supervisor, and Ms. Judith Gedrose RN, MN, who is the nurse consultant with the PHHV program. Ms. Buss is responsible for the administrative aspects of the program including contracting and budgeting. Ms. Gedrose is responsible for program monitoring and evaluation and training, and works closely with Ms. Buss to assess the overall program effectiveness. A health educator is presently being recruited to help monitor programs and to assist with Medicaid targeted case management billing which supports PHHV activities. This health educator position will be partially supported (approximately 24%) by ACA funds.

The Epidemiology Unit includes two master's prepared epidemiologists and one bachelor's prepared data manager. These staffs have and will continue to work closely with PHHV and MCHC staff to compile, analyze and interpret data regarding MCH risk and need. Both epidemiologists are trained in the use of statistical software (SPSS and SAS) and in statistical techniques, including small number analysis that is frequently a concern in frontier and rural states. The Epidemiology Unit staff also has access to consultation from the lead epidemiologist and medical officer for the state, as well as to other epidemiologists in other bureaus within the division.

Barriers to and Opportunities for Coordination of HV NA with Other NA

As in other states, Montana has just completed the required 5 year MCH needs assessment. The staff that developed the NA is located in the MCHC section and MCH Epidemiology Unit, and due to the small size of the state, is very familiar with all data compiled for the needs assessment. Data gathered for the Needs Assessment includes an analysis of the birth demographics and birth outcomes for the state by county. The MCH Epidemiology Unit also gathered the MCH data needed for the Community Health Assessments that are being published this month; that data will contribute to the planned home visiting needs assessment.

The annual MCH pre-contract survey is also managed and analyzed by the MCHC Section and Epidemiology Unit, allowing this year's survey to be efficiently modified to gather data needed for the anticipated funding and home visiting needs assessment. This "intimate" knowledge, due to small staff numbers is both an advantage and a challenge, as the small staff has many responsibilities. A Maternal Child Health Bureau supported Graduate Student Intern (Mallory Quigley) is working with Bureau staff during the summer and is a valuable asset by helping gather and compile of survey data.

The MCHC Section Supervisor (Ann Buss) meets monthly with Mary Jane Standaert, the Head Start Collaboration director and participates on an Early Childhood Communication group that was formed in late 2009 at the direction of the DPHHS director. In the course of those meetings, the MCHC Section supervisor is well aware of the information contained in the Montana Health Start Collaboration Needs Assessment, which was last updated in 2009. The priority areas for the Collaboration work including Education/Professional Development, Health/Mental Health/Oral Health, Child Care, Disabilities, Welfare, Homelessness, Family Literacy, and Community Services. As indicated in the letter of concurrence from Ms. Standaert, the Head Start Collaboration Office recognizes home visiting as a valuable mechanism to address many of the priority areas identified in the needs assessment. The eight early head start programs in the state are of particular interest, due to the home care component in the early head start design.

PHHV programs in Montana have historically coordinated efforts with child abuse prevention programs, often providing a primary prevention opportunity for families considered at risk for abuse due to history of substance use, even before entry into or involvement with the child protection system. The chair of Montana's Children's Trust Fund, Ms. Betty Hidalgo, is a longstanding proponent of PHHV services in Montana, and is committed to coordinating Children's Trust Fund activities with the ACA Home Visiting effort. Ms. Hidalgo, who is also a board member with the National Alliance of Children's Trust & Prevention Funds, spearheaded a resolution on Children's Trust Funds and Home Visiting which encourages MCH programs to closely coordinate with Children's Trust Funds in order to maximize public and private resources supporting home visiting services. A copy of the resolution, which was passed June 25, 2010, is included in Attachment 5.

State Approach to Conducting Assessment of Needs

As stated earlier in this document, Montana is conducting surveys of local programs to determine the availability and reach of existing home visiting programs. Staff and/or the student intern will follow up on surveys via telephone to clarify any outstanding issues. Data from the Community Health Assessments will also be readily available for the home visiting needs assessment. Bureau staff and contractors (as needed) will compile the needs assessment based on federal guidance.

Stakeholders include all existing PHHV contractors, all Head Start and Early Head Start agencies, state agency partners, including staff from the department Director's Office, the Early Childhood program, the Addictive and Mental Disorders Division, Medicaid, SCHIP, and the Children's Trust Fund, and MCH advocacy organizations such as Healthy Mothers, Healthy Babies, the March of Dimes, the Montana Council for Maternal Child Health. The state agency has a long history of collaboration with the listed partners, and will continue to solicit input and participation through meetings and other communications. ACA Home Visiting data has been placed on the Bureau website, an e-mail group developed and a special e-mail address created for state and local partners to communicate regarding home visiting program development.

Anticipated Need for Technical Assistance

Montana anticipates requesting technical assistance in the area of defining adequacy of home visiting programs. Montana may also consider requesting resources for a facilitator to help partners to reach consensus on decisions regarding the number and type of models to be adopted. Montana will also request technical assistance for the development of an evaluation plan for the new home visiting program which will be developed.

Statement of Intent

Montana does intend to apply for grant funding to deliver evidence-based early childhood home visiting services, as described in section 511(c). Montana will complete and submit a needs assessment per federal guidance on or before September 1, 2010, and will complete and submit a plan for maternal, infant and early childhood home visiting by a date yet to be determined and according to federal guidelines. Montana considers the funding an excellent opportunity to coordinate, expand and improve existing home visiting services for MCH populations, by assuring that home visiting services for the MCH populations in Montana are grounded in science and effectively implemented.

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